TRAUMA REGISTRY ADVISORY COMMITTEE (TRAC)
MEETING MINUTES
July 9, 2004

Attendees: Steve Millard, Chris Leeflang, Alnita Nunnellee, Bob Seehusen, Lynette Sharp, Murry Sturkie, Leslie Tengelson. EMS Bureau representatives: Kay Chicoine, John Cramer, Dia Gainor, Richard Schultz, Carolyn Thrasher.

TOPIC	DISCUSSION	MOTIONS/ OUTCOME/ TASKS
Welcome & Introductions & Review Minutes		Minutes approved
Hospital Trauma Registrar Subcommittee Report	Lynette reported on the survey she conducted targeting hospitals with 100+ beds. Eight responses were received and four did not respond. (Bingham, EIRMC, Madison, Mercy Medical, MVRMC, Portneuf, St Alphonsus, St Joseph, St Luke's, Teton, West Valley) Six questions were asked of the Coordinator or Emergency Room doctor. It was found that many hospitals do not know what the committee is doing. The question regarding what the impact of a web-based site was asked. Five respondents are already inputting information: 4 are using TRACS and 1 is using Collector. The need to interface existing data was stressed. The need for confidentiality of data is critical. Facilities want the data to be used. They would need help in learning whatever program is selected. PROS: Multiple access No costs for software Fast and easy Instantaneous Ability to customize CONS: Fear of unknown Will it be user friendly Will facility be able to run and own their reports QI Responders do not want to duplicate data entry Three facilities are willing to be test sites:	Dick stated that the Trauma program will continue. Even if legislation goes away, the State will not back off.

	Teton, Madison and Bingham but would need help. Dr. Sturkie asked what the response was to customizing data. Lynette said the facilities want to use what they are already using. Dia suggested a model of the registry be used as a demonstration to smaller hospitals. Lynette did not receive responses from the smaller hospitals. She did follow-up phone calls and found there was a low level of understanding of the program and concern as to implementation and cost. Dia said there needs to be more awareness of the program, possible grant ability, and the implementation process. Dick suggested keying in on understanding both the value and use to the facility as well as patient outcome. Concern was expressed about hospitals becoming involved with program and then State funding not being available to assist with expenses.	
ICD-9 Code Inclusion	John handed out "Classification of Death and Injury Resulting from Terrorism". Dia said "user definable" options were available unique to hospitals and also for general use. Chris defined I-codes. ICD9 codes must have E (Event) codes determined by Motor Vehicle Division. ICD9 codes are for a specific injury and are used for billing. Terrorism codes are E-codes with ICD10 coding. Chris will follow up for further definition of when ICD10 coding would be used.	
TRAC Progress Information	Committee members expressed concern about the lack of knowledge of hospitals about TRAC. Steve said information has gone to hospital CEO's. Dick suggested a presentation be prepared to be distributed via conferencing, WebEx, or other means with availability for questions and answers. He said it should be decided what message would be specific to hospital personnel and what would be directed to physicians. The physician's message should be very brief, perhaps with bulleted points. Bob asked that a brief presentation be put	Suggestion to send information to both CEO's and ER directors. COMMUNICATION TO: ▪ Hospitals: Registry personnel / Non-registry personnel ▪ CEO / Registrar / CNO ▪ Physicians (IMA list) ▪ ED ▪ Director of Nursing ▪ EMS agencies ▪ Office of Highway Safety

	together for physicians, possibly distributed by the IMA board. Dick suggested a reminder to ER doctors that they started the process, now what do they want? Lynette said it should be done by the next quarter as the test project is to start Jan. 1, 2005. Dick asked there be opportunity for input prior to choosing a system and implementation of the project. Dr. Sturkie suggested a letter be sent with link to the Bureau website where more details could be available. Lynnette did not want a rehash of information from the beginning of the TRAC. Kay felt a need for a subcommittee to develop communication and education objectives. Dia felt it should be a marketing tool. Letters to have a common message, with committee status. Brief history with purpose to educate about committee and give update on progress with emphasis on benefit to hospitals. Hospitals should be told the identified criteria. More detailed information to actual workers in system. General information to everyone else with web link to IMA, IHA, EMS. Bob suggested frequent updates with timeline projections, tied to meeting dates showing what was accomplished. Dick felt the information must be dynamic; when information is needed, send out, don't send if nothing of importance. Concentrate information via WebEx to those who will be impacted. John reported on information given at the IHA South East Conference. Response was positive but there was concern about a "report card" of treatment. The Cancer Registry program works well. The SE IHA conference has good attendance in the summer but the Southwest conference does not. The North conference had too little interest so no presentation was made.	▪ Vital Statistics ▪ Senator Darrington ▪ Governor ▪ JFAC – germane committees ▪ Special Interest Groups, AAA, Insurance companies, Congressional delegates (refer to funding [HRSA]) ROUTES OF DISTRIBUTION: ▪ Newsletter ▪ Web-X ▪ Direct mail/ USPS ▪ Portal/ web site ▪ E-mail ▪ Speakers Bureau ▪ Public Information / press release LETTER: ▪ IMA letterhead on physicians letters ▪ EMS letterhead to EMS agencies ▪ ACEP letterhead FREQUENCY: ▪ Matrix-specific to audience ▪ 2 – 3 notices MARKETING: ▪ History ▪ Plan ▪ Impact / Actions ▪ Benefit EVALUATE: ▪ Who to target with information (registrars, CNO's, etc.) as opposed to hangers-on with little real interest A summary document to be prepared now for presentation to IHA and IMA.
Hospital Expense Reimbursement	Concern was expressed about how hospital expenses would be met. Stipulation was made that this should not be a money-making program for participating hospitals. Dick recommended a set fee as opposed to	Participating hospitals would do so on a voluntary basis the first year, beginning July 06, with reimbursement in subsequent years, beginning with July 07.

	reimbursing hospital expenses as this would be difficult to control or monitor. A report showing how Utah reimburses for the trauma program was shown. This is a 3-tiered program: Trauma Centers ▪ Trauma Basic full service software ▪ No reimbursement Medium > 200 patients annually ▪ Trauma Basic (data entry and canned reports) ▪ $25 for two charts or per hour ▪ Mini-grants annually according to number of patients Small <200 patients annually ▪ Copy and mail records ▪ Reimbursed $10 per record ▪ (NEDARC) Estimated start-up costs at $250,000 - $300,000 with annual fees of $185,000. The perception is that hospitals will not bear the cost of Trauma Registry expenses. Worst case scenario would be that no rule making be done and all hospitals would participate on a voluntary basis. A decision for fees was postponed until the next meeting. Details will be discussed with CEO's. The IHA has a meeting in mid-August.	Cost prediction could be made after review of first year.
Grant Funding Life and Amounts	John presented a schedule detailing the different grant funds with termination dates. At this time there is $320,000 from three grants. Each grant has a different termination date. Because most of the expenses to date have been used to cover TRAC meeting expenses, some EMSC grant monies are being used for the Pediatric Prehospital Courses scheduled throughout the state. Future EMSC grants will be dependent on Federal guidelines. Grant funds need to be used by the termination dates or could be lost. Chris will discuss the SARMC Festival of Trees matching grant with the Endowment Fund committee to see if end date can be extended. If so, these funds will be used for backfill after the Federal grant funds have been used. Dick said the Contractor would need to develop a budget with time frames tied to the grant expiration dates. Funds must be used to pay contractor reimbursement, not for future	

	expenses.	
Dedicated Funds Report	Dia had partial information available because she had a meeting that afternoon with the budget analyst. Usually there is some increase from Dept. of Transportation due to population increase. Projections are difficult due to driver's license changes (i.e., addition of 8-year licenses). Dedicated I funds come from vehicle registration, Dedicated II funds are from driver's license fees. Dedicated III funds come from driver's license fees and are used exclusively for acquiring vehicles and equipment used by EMS personnel. Receipt income comes from a contract the Communications Center has with Idaho Department of Transportation for road reports and Bureau certification fees for AEMT-A's and EMT-P's. This is the last year for Federal Temporary Assistance to Needy Families (TANF) income of $100,000. The Poison Control and Patient Care Report expenses come from these funds. Unused funds remain in the State account and could be taken for other purposes by legislative action. Dia expects to request additional appropriation due to excess dedicated funds. This requires legislative action and would not be effective until FY06, at the earliest. If FY06 appropriation does not happen, FY07 could coincide with grant funding termination. While dedicated funds may be used by for the Trauma Registry, general State funds may not. Dick will contact Senator Darrington for involvement and support for appropriation to fund ongoing expenses. Grant funds may be used for start-up expenses. There is a possibility to request a fee increase if an actual need is shown.	
2005 Annual Report	Statute requires an annual report. There was little response to last year's report. Dia suggested the report start with last year's report and update the contents for current year. The report is distributed to legislators the first or second week of session. Information should go to hospitals and physicians prior to annual report distribution so they are knowledgeable about the program.	Final review of the report by committee in December.

Trauma Registry Scope of Work	A RFP needs to be done immediately. There needs to be a close partnership between the State and Contractor.	Headers: Outreach and Communication Partnership between EMS Bureau and Contractor Contractor is to do all: ▪ Determine software and obtain necessary license. ▪ Must be web based. ▪ Format of data. ▪ Ensure HIPAA is covered (data must be de-identified, linkage is ok). ▪ Determine limitations of data to Office of Highway Safety. Administrative presence: ▪ Contractor to meet needs of hospitals. ▪ Uploading of data on one-time basis. ▪ Business hours (Technical support, Training, Help desk). Software selection by EMS Bureau and Contractor. QC / QI between EMS Bureau and Contractor. Reports available via web or hard copy. Analysis: ▪ Determine reports available at no charge. ▪ Determine fees for specialized reports. ▪ Mandate direct access to participating hospitals and State agency. ▪ Contractor deliverables. Evaluation after six months: ▪ Bureau ▪ Participants Compliance: ▪ Non-compliance report by Contractor to State. Contractor default: ▪ Cover in contract Contract renewal annually on

		four year contract with 90 day notification.
Attendance	Concern raised as to lack of attendance at meetings, declining each meeting.	Steve, Dick and Dia will review membership list to see if action is needed. May look at membership for representative changes based on future direction.
Next Meeting	The next meeting and partial agenda was set.	September 10th, 9 – 3 Agenda: ▪ Overall plan. ▪ Hospital reimbursement (feed back from IHA about hospital reimbursement). ▪ Gap funds analysis. ▪ RFP update. ▪ Linkage agreement – decision by committee. ▪ Committee membership.
Adjourn	Meeting was adjourned by Chair	